INITIAL HEALTH SCREEN

Youth Name: Case No. Date:

1) Health Screen

Y N R U (Y=Yes, N = No, R=Refused, U=Unknown)

☐☐☐ Is this the first time you have been arrested or detained?

☐☐☐ *Are you currently being treated for an illness or injury? Are you sick right now? Have you had an untreated injur
If yes please explain: _____

☐☐☐ *Do you have any infections, communicable diseases, rashes, or unexplained itching? (i.e. hepatitis) If yes, expl
_____

☐☐☐☐ *Females Only: Are you pregnant, or suspect you might be pregnant? Last menstrual cyc _____

☐☐☐ *Is there any reason you need to see a doctor or nurse immediatel

☐☐☐ Do you have any of the following

☐ Epilepsy (seizures)	☐ Tuberculosis	☐ Teeth Problems	☐ Frequent Headaches	☐ Anger Problems
☐ Diabetes	☐ Mononucleosis	☐ Eye Problems	☐ Skin Problems	☐ Back/Joint Problems
☐ Asthma	☐ Panic/Anxiety Attack	☐ Ear Problems	☐ Heart Problems	☐ Other (specify)
☐ Hepatitis	☐ Blood Disorders	☐ Mood Swings	☐ Stomach Problems	
☐ Diarrhea	☐ Kidney Problems	☐ Depression	☐ Sleeping Problems	

☐☐☐ Are you using a prescribed medication for these or any other condition

☐☐☐ An over the counter medication? If yes, is the medication present

Name of medication(s): #1 _____
#2 _____
#3 _____

☐☐☐ Have you ever been under the care of a psychiatrist, therapist, or mental health professiona
If yes explain: _____

☐☐☐☐ Are you on any medical special diet? How long? If yes, expla _____

☐☐☐☐ *Are you allergic to any medications, nuts, insects etc? If yes, wha _____

☐☐☐☐ *Are you allergic to any foods or other substances? If yes, wha _____

☐☐☐☐ Are your immunizations (shots) up to date

☐☐☐ Is there anything special we need to know about you for your safety, welfare, and protectio
If yes, explain: _____

2) Suicide Assessment

☐☐☐ Have you ever thought about committing suicide

☐☐☐ Are you thinking about it now

If yes, do you have a plan? _____
Specify how and when: _____

☐☐☐ Have you ever attempted suicide in the past

If yes, please explain: _____

☐☐☐ Have you ever hurt yourself or taken unnecessary risks

If yes, please explain: _____

☐☐☐ Have your eating or sleeping habits changed recently

If yes, please explain: _____

☐☐☐ Have you used any alcohol or drugs in the last 48 hours?

If yes, please explain: _____

How would you rate your self as a suicide risk on a scale from 0, no risk to 10, high risk? _____

3) Observations by Intake Worker

☐☐☐ Does the youth appear to be intoxicated or withdrawing from drugs or alcoh

☐☐☐ Are there visible signs of alcohol or drugs

If yes, please explain: _____

☐☐☐ Does the youth appear agitated, paranoid, mentally ill, hopeless, aggressive, or feeling severe shame or gu

How would you rate the youth as a suicide risk on a scale from 0, no risk to 10, high ris _____

If it is determined that there is a suicide risk, please continue with additional assessment.

List preventative measures needed _____

☐☐☐ Does the youth have any obvious pain or injury

If yes, what? _____

☐☐☐ Does the youth have any body deformities, trauma markings, bruises, cuts, bleeding, jaundice, skin rashes, tattoos, or piercings?

If yes please explain: _____

☐☐☐ Does the youth appear to be: mentally confused, disoriented, irrational, mentally ill, mentally challenged, exhibiting abnormal, check all that apply.

If yes explain: _____

☐☐☐ Does youth appear to be despondent or depressed

Staff comment: _____

Staff Completing the Assessment: _____ Date: _____

Place one copy in the youths file and give one copy to the nurse.

Based on my assessment I am placing this youth on suicide watch and requesting further testing.

Date: _____ Time: _____

(Only a supervisor can end a suicide watch)